Jesuit High School
Authorization for Medication Administration
by Designated School Personnel

TO BE COMPLETED BY PARENT/GUARDIAN
Student Name:
DOB/Grade:

This form must be completed and signed by a parent/guardian and the physician of the student before a medication can be administered at school. If the student will be self-medicating the Self-Medication Agreement form needs to be completed in addition to this form.

I give school personnel permission to administer this medication per the following instructions: I understand I am responsible to provide this medication and maintain the supply as needed. All medications must be in their unexpired, labeled, original container. I understand that I am responsible to notify the school of any medication changes in writing and that all staff-administered medications are to be brought to and from school by a parent/guardian. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. Students must not share over-the-counter and/or prescription medications or will be subject to disciplinary action.

Medication Name:

Dose (Prescribed Amount, e.g. 5 mg, not 1 pill):

Frequency: Reason for medication:

Route (circle one): Mouth, Ear, Eye, Nose, Skin Start Date/End Date:

Special Instructions:

Parent/Guardian Signature:_____Date:_____

TO BE COMPLETED BY THE PHYSICIAN:

_____I have prescribed the above medication for the student whose name appears on the top of the form
_____Instructions from the parent are accurate
_____I certify that this medication is necessary for the student to remain in school
_____Student is able to self carry and self administer this medication.
_____Special instructions including adverse reactions and action required: _____

Physician Name:_____Phone:_____

Physician Signature: _____ Date:_____

School Health Nurse Signature:_____Date:_____